EXHIBIT 9

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL)
INDUSTRY AVERAGE WHOLESALE) MDL No. 1456
PRICE LITIGATION)
_____) Master File
) No. 01-CV-12257-PBS
THIS DOCUMENT RELATES TO:)
_____) Subcategory
) No. 06-CV-11337-PBS
United States of America,)
ex rel. Ven-A-Care of the)
Florida Keys, Inc., v.)
Abbott Laboratories, Inc.,)
CIVIL ACTION NO. 06-11337-PBS) VOLUME I

Videotaped Deposition of JAMES W. HUGHES, Ph.D., at 77 West Wacker Drive, 35th Floor, Chicago, Illinois, commencing at the hour of 9:13 a.m. on Tuesday, May 5, 2009.

Page 126

Q. And do your opinions in this case also draw upon any expertise you have in law and economics?
A. Well, to the extent if you define law and economics as being restricted to the idea of the common law moving away from inefficient rules towards efficient rules, probably not.
But to the extent that law and economics is a discipline with a certain outlook on how markets and actors within those markets work, I can't say it doesn't influence my thinking at all. But I don't think I can point to something in my report that says yes, this is a law and economics point.
I mean all of these are just applied micro-fields, and my point is I'm a broadly practicing applied micro-economist.
Q. So your area of expertise or areas of expertise you're drawing upon in connection with this case include applied micro-economics, health economics, labor economics, industrial organization, antitrust, and law and economics?

Page 127

A. You know, I think that's kind of overly broad. I mean they're all subfields of, they're all fields of applied micro-economics.
So I only hold myself out here as being an applied micro-economist. That's the main thing one needs to understand to understand what's going on in this case in my opinion.
Q. Now, the consulting work that you've done over the years in the health arena, what experience do you have as a result of your consulting work that qualifies you as an expert to testify in this case?
A. Well, I believe, as I said before, in my role as a consulting and testifying expert, I've had to familiarize myself several times over the years with drug reimbursement policies of state Medicaid agencies, Medicare, third-party payors, pharmacy benefit managers, and the like.
The assignments have called on me to familiarize, I would say to deepen my familiarization with medical markets of all kinds, but, you know, particularly in the

Page 128

pharmaceutical areas since that was the area where I was doing most of the work.
Q. When have you worked on drug reimbursement policies as related to Medicare and Medicaid in the past?
A. I would say fairly confidently in every one of the class certification matters in pharmaceuticals.
Q. Were there any other of your consulting engagements that provided or support any of your expertise in drug reimbursement policies for Medicare and Medicaid?
A. Well, certainly my previous work in Connecticut and Montana, Nevada.
It came up in, well, that was a class certification matter.
Certainly in my role as a consultant in Cardizem. That was the, I spoke about serving as a consultant when there was an opt-out plaintiff, which was a third-party payor. So I had to, in order to construct the damage estimates that we made, I had to become familiar with the ins and

Page 129

outs and the practices of that particular third-party payor, what their policies were towards reimbursement, what their policies were towards putting brand drugs versus generic drugs on the formulary, where on the formulary they would put them, under what circumstances, what would change when they would carve out their pharmacy benefit and have it run by a pharmacy benefit manager, what sorts of rebates and under what circumstances that they could get, did get or could get, from brand name pharmaceutical manufacturers, what sorts of incentives they were given by state, federal, or simply profit motives for moving from brands to generics on the formularies, things like that.
Very detailed, it required getting very detailed knowledge about how a number of different reimbursement systems were working.
Q. Did any of your prior cases involve analysis of the individual claims paid by a portion of the Medicaid programs?
A. There was time that we, in many of the

Page 130

class certification cases I would make use of these, what's the acronym, the state utilization, state Medicaid utilization data that appears on the web, or at least used to appear on the web. So that's aggregate rather than individual claims data.

But there was analysis and manipulation of those data in the course of that work. And that was two or three or four of those cases that we've talked about before.

Q. Are you talking about what is referred to as the STUD data, S-T-U-D?

A. I think so.

Q. Have you ever worked with the SMRF/MAX data before?

A. I have not, no.

Q. Your work with the STUD data -- I'm sorry. Did you base any of your work on that data?

A. I'm sorry. I need to correct something previously.

There was individual Medicaid claims

Page 131

data that we analyzed in the Connecticut matter. I'm sorry. I left that out.

Was that SMRF data, was that MAX data, I don't recall, but it was individual claims data that was provided by the state.

It just seems to me there was, HUGR, H-U-G-R, was the acronym that I remember that as I recall was data that was provided to us by Connecticut Medicaid.

Q. Was that claims level data?

A. Yes.

Q. So it would show on a particular date a particular person got "X" units of a particular drug?

A. Yes.

Q. Did that data cover, well, describe the scope of that data.

A. Well, it was specific to the drugs at issue which were primarily Taxotere and Anzemet, which were Aventis drugs.

So it was, you know, relative to other Medicaid data I think it was relatively small

Page 132

because these were, they're not chemo drugs but they are anti-hematics, to relieve nausea in chemo patients. So it was a relatively small market because it was restricted to the State of Connecticut. But, as I recall, there were still several thousand of those claims.

So what we were doing was that the plaintiff's expert had said, and I'll always remember this number, that Medicaid reimbursed for these drugs at 90.25 percent of AWP.

So we went into the claims data to review exactly what was the reimbursement because regardless of what plaintiff's expert was saying, the state regulations for part of the period said that these drugs would be reimbursed on an as-billed basis up to $499. And then if the doctor billed more than $499, the claim would be reviewed, rejected, reduced. But up to $499 it would simply be accepted.

So we got into looking at the individual claims data to see what was actually reimbursed and in effect what was the

Page 133

relationship between these reimbursements to the reimbursement formulas that the plaintiff's expert was claiming, what was the relationship of the individual reimbursements to the amounts that the state was saying it was reimbursing.

Q. Just one quick clarification and then we're done with the tape.

The Connecticut data related to several thousand claims? Is that what you said?

A. To the best of my recollection.

Q. So it was smaller than the data we're dealing with this case?

A. Well, it was one state. It was two relatively restrictive drugs. And it was over, yes, several thousand would be about right, yes.

MR. LAVINE: We better take a break.

THE VIDEOGRAPHER: Going off the record at 12:06 p.m.

(A recess was taken.)

THE VIDEOGRAPHER: Beginning of Videotape No. 3. Back on the record at 12:15 a.m.

Page 134

BY MR. LAVINE:
Q. With respect to your prior experience, in any of the other cases that you worked on as an expert or a consultant, did you get the actual underlying claims data and perform any analysis on it?
A. It's my understanding that's what we did in Connecticut, yes, to the best of my recollection.
Q. But does that mean you didn't do it but somebody else did it?
A. Yes. Somebody else did it at my direction, yes.
Q. Were there any other cases where you actually got Medicare and Medicaid data and did an analysis of the paid claims?
A. Well, the paid claims, like I said, I've used the utilization data that's online, but that's not, what I used was not individual claims data.
Again, in the Cardizem case it was individual claims data from a third-party payor

Page 135

but not from Medicaid.
Q. Just to clarify. In Connecticut who did the actual hands-on analysis of the claims data?
A. A company called The Brattle Group was retained to keep custody of the data and to do what I asked them to do.
Q. Can you spell that?
A. Brattle Group?
Q. Yes.
A. Sure, B-R-A-T-T-L-E.
Q. Is there any other reason that the consulting work that you've done helped to qualify you as an expert for the issues you're addressing in this case?
A. Well, again, in virtually every one of the class certification cases, in fact I think in all of the class certification cases --
Q. Pharmacy-related.
A. Pharmacy-related class certification cases, there is the issue of how, I mean these are proposed damage methodologies.

Page 136

So in order to assess the adequacy or inadequacy of any particular damage methodology, you've got to go into the nitty-gritty details of everybody who is or wants to be a member of the putative class.
So that means going into the payment methods and the practices of all sorts of third-party payors, not just private insurance companies, but also to the extent, also Medicaid, to a lesser extent Medicare, because the drugs that it, for example, Cipro wasn't a drug that would be covered under Medicare Part B. And prior to Part D Cipro wouldn't be covered under Medicare, but certainly Medicaid was a big user.
On the other hand, Taxotere and Anzemet, they're drugs more like the drugs in this case. So Medicare and Medicaid are both at issue there.
But in order to form an opinion about any particular damage methodology, you've got to have a pretty intimate knowledge of what data are going to be available, what are the practices and

Page 137

procedures of all of the actors who want to be members of this proposed class.
So at least to, and that research, regardless of who was doing data analysis at my direction, that research was all done by me. This was not anything that lawyers gave to me. This was not anything that I told a consulting firm to go find out what you can find out about this.
The standard practice was rather for me to do the research and then tell the consultants okay, here's what we know about Medicaid for the Medicaid say CHIP program, Child Healthcare Plan in the state of Illinois, all right, so go look at the data and tell me, you know, are the reimbursements that are supposed to be in this and the copayments that are supposed to be in this and this was actually showing up in the data.
So, yes, I considered that through all of this I have a fairly detailed knowledge of Medicaid and Medicare pharmacy reimbursement

Page 142

Q. -- as that supports your expertise in this case.
You said you were trained in health economics. What training in health economics are you referring to?
A. Classwork. I was planning, before I turned to medical malpractice, I was planning on doing my Ph.D. thesis on a healthcare topic.
So there was a lot of background reading of journal articles and books that I did in preparation for that. And I just never, I just chose to go a different direction once I got exposed to law and economics. The topic was more interesting, the data were more readily available, so I went that route.
So that's why I consider myself to be trained in health economics.
Then also when you teach a course, maybe some people do it this way, but the lay person, if I may, may think you pick up a textbook and you teach from that. But that's not really the way teaching works.

Page 143

I was certainly qualified, felt qualified, to teach health economics. So then you go through, in my experience when I'm doing a new course I spend six to eight hours preparing for every hour in the classroom.
So that's going to be not just dealing, and, in fact, probably not dealing much at all with the textbook, but rather familiarizing one's self with journal articles and other materials that you need to teach the course that you're going to teach.
Q. When you talk about classwork, you're referring to when you were a student?
A. Well, in that answer I was referring to both.
Q. Well, first as a student and then as a teacher.
A. Right.
But as a student, again, the training was, I simply don't remember. I don't know that I ever had a course entitled "Health Economics," although I took courses in health law at the

Page 144

Michigan Law School.
When I was an undergraduate, I was a research assistant for health economist when I was at Boston University. So there was a lot of training in there.
But maybe as an undergrad, I can't remember if I ever took a course that was entitled "Health Economics."
Q. In terms of your experience in labor economics, industrial organization, and antitrust, and law and economics, is the basis for those similar as to what you just described for health economics?
A. No.
I have certainly studied law and economics and of course taught it several times.
Labor economics I did not take a course in.
Industrial organization I had several courses in, three that come to mind off the top of my head.
So there is much more academic training

Page 145

there.
Q. In any of your work, have you actually calculated a damage figure in a false claims case?
A. In a false claims case, no.
Q. Have you ever done any data analysis where you would extrapolate from experiences in one Medicaid program to the reimbursement experience you would see in another Medicaid program?
A. Not to my recollection, no.
Q. Have you had any prior experience in connection with analyzing damages in connection with the Medicare program J-Code reimbursement?
A. Calculating damages, no.
Q. Any type of reimbursement experience related to Medicare J-Codes?
A. Certainly in the AWP litigation, I certainly had to know something about it for the reports that I wrote.
Q. Did you look at the way any state Medicaid programs may have reimbursed based upon

Page 250

(The record was read back as requested.)
BY MR. LAVINE:
Q. So am I right though that you have no opinion regarding the level of precision that would be necessary in order to extrapolate from the existing arrays?
MR. BERLIN: Objection, form.
THE WITNESS: I don't think that's accurate.
What I have said now several times is that when one makes an assumption, the assumption needs to be reasonable.
The standard for the reasonableness of the assumption is can you point to some evidence, any kind of evidence, that says that this assumption is reasonable, has a basis in the facts of the case, has a basis in the practices in this case of the Medicare carriers, does it have any basis whatsoever.
I am certainly not, I'm an economist, I'm not saying that you can do analyses all the

Page 251

time, that you can always do analyses without making assumptions.
I mean economists, and I'm included in this, we make assumptions in our analyses all the time.
But one of the criticisms of Dr. Duggan is he makes assumptions, he doesn't always spell out the assumptions that he's going to be making. And when he doesn't spell out the assumptions that he's going to be making, or when he does or doesn't spell out the assumptions he's going to be making, he rarely if ever provides the basis for the assumption that he's making.
So that's where I'm at on the Medicare arrays, is I might believe him if he can give me documents, if he can give me testimony, if you all can provide an affidavit that says that there's standard practice for this, these arrays followed the standard practice, everybody else follows the standard practice, I'm not going to have much of a problem with that.
But that's not going to be, and that's

Page 252

not going to be a situation where everybody is going to be exactly the same. But, more or less, there's a procedure that's followed, and, more or less, you can look at the arrays that we have and come to the conclusion that for the most part, not a hundred percent of the time, but for the most part people are following those procedures. And you give me that and say well, I'm going to then assume everybody else also follows those procedures, I don't have that much of an objection to that.
Again, it's going to depend on what the evidence is that you give me that there are these procedures and everybody's following. You know, give me a basis and then let's kick around whether it's reasonable or not.
But at this point Dr. Duggan hasn't given me any basis for that assumption. And the evidence that we do have suggests it's a very bad assumption. And that's what my objection is.
BY MR. LAVINE:
Q. What is the standard that you're going

Page 253

to hold professor Duggan to beyond just saying that what he does needs to be reasonable?
MR. BERLIN: Objection, form.
THE WITNESS: I did not say what he does needs to be reasonable.
I said that his, the assumptions that he makes need to have a reasonable basis in fact, that you're just not making some assumption because it's convenient but you have every reason to believe as I believe we have here to think that this assumption is not valid.
BY MR. LAVINE:
Q. So if Professor Duggan had a reasonable basis in fact regarding his assumption that the Abbott products were used in the other arrays, then that would be an acceptable methodology, and your problem is he did not articulate that for you?
MR. BERLIN: Objection, form.
THE WITNESS: We're on to a different subject now. I mean what we were talking about before was the arrays he does have versus the

Page 254

arrays that he doesn't have, right.
But I am in basic agreement with you that if he says here's the assumption I'm going to make about the similarity or lack of similarity of the arrays I do have to the arrays I don't have, and he's made that assumption, he hasn't stated it but he's made the assumption that the arrays I don't have look like the arrays that I do have. He hasn't stated it but you can figure that out that he is assuming that, and he says in his report here's why I think making that assumption makes sense.
To me, an unacceptable reason why this assumption makes sense would be something like I don't have anything else to do, this is all I got, and I got to use the arrays I have, and I'm just stuck with it, and so whether it's right or wrong I just got to use these arrays.
That's not a reasonable basis for making the assumption. An assumption is a rebuttable presumption.
So if he then were to say in his report

Page 255

well, everybody knows that arrays are all constructed in the same way, everybody knows that Medicare has been on the phone with these folks, and everybody knows that there's some standards that are applied to these arrays, so the ones that I don't have are going to be just like the ones that I do have, okay, that's a basis.
Then we get to kick around whether it's reasonable or not. And one measure whether it will be reasonable, okay, let's look at the arrays that you do have, are they constructed the same way, do they have the same number, constructed the same way, are they constructed according to the standard that you say has been communicated to the carriers by CMS or HCFA or whoever is in charge at the time.
If it does, fine. Then we may well agree that this was a reasonable assumption with a reasonable basis.
An example of a more reasonable basis, as I've said before, is that if there were Medicare regulations that said here's how you do

Page 256

arrays, and that the arrays that Dr. Duggan had in his possession, again, not a hundred percent of the time but the vast majority of the time it's clear that these carriers followed those regulations in constructing those arrays.
And so then he says in his report well, everybody that I do have is following these regulations fairly closely, so I think it's a reasonable assumption to make that the people that I don't have also followed these regulations reasonably closely. So I'm going to assume that the arrays that I have are the same as the arrays that I don't have.
He and I could kick that one around and I may well come to agree with him yeah, under the circumstances that's reasonable because the evidence that we have both of the regulations and how those regulations are or are not reflected in the arrays that we have matches up well enough such that yeah, okay, I can see that being reasonable.
But we're in a situation now where he's

Page 257

just simply making an assumption, and he's provided me, not provided to me, he provides the reader with no basis for why that should be reasonable.
And, the evidence that he does have in his possession, the arrays that he does have, suggests that that assumption is not reasonable because these arrays vary greatly in the way that they're constructed and the way that they're put together across carriers and across time.
BY MR. LAVINE:
Q. And another consequence of that issue is that there would have been no way for Abbott to have known whether it would have gotten a benefit from any alleged AWP manipulation?
MR. BERLIN: Objection, form.
THE WITNESS: No. That's not quite what I said.
BY MR. LAVINE:
Q. I apologize. Correct me.
A. No, that's okay.
What I was saying was because of the